83-1493

IN THE

Supreme Court of the United States

OCTOBER TERM, 1983

No:

GENERAL HOSPITALS OF HUMANA, INC.,
Petitioner,

v.

ARKANSAS STATEWIDE HEALTH COORDINATING COUNCIL, *et al.*,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF THE STATE OF ARKANSAS

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QUESTIONS PRESENTED

I. Whether Congress intended, in the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§300k *et seq.*, to prohibit the states from approving the construction of needed hospital beds solely because those beds might exceed certain general numerical guidelines suggested by subsequent federal agency regulations.

II. Whether Congress intended, in the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§300k *et seq.*, to delegate effective decision-making authority for health planning to citizen and industry advisory panels (Health Systems Agencies and Statewide Health Coordinating Councils) rather than to the State Health Planning and Development Agency, required by the Act to be an agency of state government, and whether such a delegation would be constitutional.

III. Whether the Arkansas Supreme Court, upon formulating a new legal standard for evaluating petitioner's certificate of need application, denied petitioner due process of law as guaranteed by the Fourteenth Amendment by failing to remand the litigation so that petitioner could have an opportunity to present evidence under the newly formulated standard.

PARTIES TO THE PROCEEDING

In addition to petitioner General Hospitals of Humana, Inc.,* the other parties that appeared as appellees before the Arkansas Supreme Court included the Arkansas State Health Planning and Development Agency, the Division of Social Services of the Arkansas Department of Human Services, and Mr. Ivan H. Smith, the Director of Legal Services of the Division of Social Services. These parties supported the issuance of a certificate of need to General Hospitals of Humana, Inc.

In addition to the Arkansas Statewide Health Coordinating Council, the other parties that appeared as appellants before the Arkansas Supreme Court included Baptist Medical System, St. Vincent Infirmary, both of which are acute care hospitals located in Little Rock, Arkansas, and Arkansas Blue Cross and Blue Shield, Inc. Those parties opposed Humana's certificate of need application by appealing the final administrative agency determination first to the state trial court and then to the state supreme court. They also opposed Humana's petition to the Arkansas Supreme Court for rehearing.

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* General Hospitals of Humana, Inc. is a wholly-owned subsidiary of Humana Inc., a publicly-traded company.

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General Hospitals of Humana, Inc. petitions for a writ of certiorari to review the judgment and opinion of the Supreme Court of the State of Arkansas entered on October 24, 1983, *petition for rehearing denied,* December 12, 1983.

OPINION BELOW

The opinion of the Arkansas Supreme Court is reproduced in the Appendix, and is reported as *Statewide Health Coordinating Council et al. v. General Hospitals of Humana, Inc. et al.,* 280 Ark. 441 (1983), *reh. denied,* 281 Ark. 98 (1983). *Infra at* 1a to 5a. The decision of the Pulaski County Circuit Court, Sixth Division, which was reversed by the Arkansas Supreme Court, is also reproduced in the Appendix. *Infra* at 1c to 3c.

These state court decisions were issued on judicial review of the decisions of the Arkansas State Health Planning and Development Agency and the Arkansas Department of Social Services, both of which are reproduced in the Appendix. *Infra* at 1e to 4e (SHPDA decision), and 1d to 16d (Department of Social Services decision).

JURISDICTION

The judgment of the Arkansas Supreme Court, applying provisions of the National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§300k *et seq.*, (the "National Health Planning Act") and implementing regulations, 42 C.F.R. §§121 *et seq.*, was entered on October 24, 1983. A timely petition for rehearing was denied on December 12, 1983. This petition for certiorari is being filed within ninety (90) days of that date. This Court's jurisdiction is invoked under 28 U.S.C. § 1257(3). *See Infra* at 1f-2f.

STATUTORY PROVISIONS INVOLVED

Relevant provisions of the National Health Planning Act and of the Code of Federal Regulations involved in this case are reproduced in the Appendix. *Infra* at 1g to 19g.

STATEMENT OF THE CASE

The National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§300k *et seq.*, created a cooperative federal-state program to oversee the nation's health care delivery system. Since passage of the Act, numerous issues have arisen concerning the delicate balance which the Act sought to achieve between the roles of federal and state government, as well as between governmental interests and those of private entities such as private health care providers and citizen-industry advisory groups. Despite the fundamental importance of these issues, this Court has had but limited

opportunity to address health planning.[1] The decision below of the Arkansas Supreme Court, review of which is sought here, squarely poses these issues and provides this Court with an opportunity to address these questions authoritatively and for the first time.

1. ***Legal Framework***

This case is before the Court on a petition for a Writ of Certiorari to review a decision of the Supreme Court of Arkansas. The federal questions presented were timely raised in the proceedings below. Petitioner's interpretation of the National Health Planning Act was argued at all levels of administrative and judicial review below. *See* Appendix 1a to 1e. The Arkansas Supreme Court's novel interpretation of that federal statute was challenged in the petition for rehearing to the Arkansas Supreme Court. *See* Appendix at 2b. The error in the Arkansas Supreme Court's refusal to remand its decision was argued in petitioner's petition for rehearing to that court. *See* Appendix at 3b.

Under the National Health Planning Act, Congress initiated a cooperative federal-state effort to oversee the provision of health care services in the United States. In general, the states are authorized to establish health planning programs and are made eligible for federal grants to fund those programs, subject to the provisions of the federal law.

Two facets of the National Health Planning Act are central to the issues in this proceeding. First, the Act directs the governor of a state to establish a state health planning and development agency ("SHPDA"), an adjudicative body whose principal function is to administer a state "certificate of need" program. 42 U.S.C. §300m-2(a)(4)(B). Under this program, the SHPDA has the exclusive authority to evaluate whether and to certify that a proposed capital expenditure for the provision

[1] The only decision by this Court construing the National Health Planning Act, *National Gerimedical Hospital v. Blue Cross*, 452 U.S. 378 (1981), dealt with the relationship of the Act to the antitrust laws, and did not directly involve questions of the implementation of the Act, although it includes an extensive discussion of the relationship among the agencies established under the Act.

of new health care services is demographically necessary. 42 U.S.C. §300m-2(a)(5). The federal statute enumerates more than a dozen criteria the SHPDA must consider in evaluating a certificate of need application. 42 U.S.C. §300n-1(c). The SHPDA decision may be appealed to an independent agency of the state government designated by the governor to conduct that review, and ultimately to the state courts for judicial review. 42 U.S.C. §300n-1(b)(12)(D).

Second, the National Health Planning Act directs the governor to establish two citizen-industry advisory organizations, the first denominated a "health systems agency" ("HSA"), 42 U.S.C. §300*l*-1(b)(1), and the second designated a "statewide health coordinating council" ("SHCC"). 42 U.S.C. §300m-3(b)(1)(A)(i). Both the HSA and the SHCC are comprised of representatives of providers of health care services, health care insurers, and health care consumers. 42 U.S.C. §300*l*-1(b)(3)(C), §300m-3(b)(1)(B). An HSA is responsible for cataloging the availability of health care services in an area designated by the governor as a geographic region appropriate for the effective planning and development of health services. 42 U.S.C. §§300*l*(a)(1), 300*l*-2(b)(1). On the basis of this information, the HSA is to prepare a "health systems plan" for the area, which, *inter alia,* describes the institutional health services that it believes are necessary to provide an adequate level of health care services to residents in the area. 42 U.S.C. §300*l*-2(b)(2). The SHCC, a statewide organization composed in part of representatives of each HSA in the state, is responsible for coordinating the activities of each of the HSAs and for integrating the health systems plans of the state's HSAs into a single, comprehensive "state health plan." 42 U.S.C. §300m-3(c).

2. *Factual Background*

On January 15, 1982, petitioner General Hospitals of Humana, Inc. ("Humana") filed an application for approval under the Arkansas certificate of need program of a proposed 150 bed acute care hospital to be located in the city of Sherwood, Arkansas, a town located in northern Pulaski County, Arkansas which currently does not have an acute care

hospital. The Arkansas SHPDA—pursuant to its responsibilities under the National Health Planning Act and Arkansas State law—determined after a two day evidentiary hearing that there was a need for the health care services Humana proposed to offer. On the basis of these findings the SHPDA granted Humana's certificate of need application in July, 1982. *See* Appendix at 1e to 4e.

The application was opposed by two competing hospitals in Little Rock and a health care insurer in the state. One of the hospitals requested a hearing before the SHPDA in which it opposed the application. All three opponents formally requested reconsideration of the SHPDA's decision and appealed the SHPDA determination at each subsequent level of review.[2]

On appeal, the Arkansas Department of Social Services, acting as the statutorily required independent reviewing agency, *see* 42 U.S.C. §300n-1(b)(12)(D), affirmed the SHPDA's determination of need and approval of Humana's application. *See* Appendix at 1d to 16d. The opponents subsequently took an appeal to the Pulaski County Circuit Court, which in January, 1983, similarly affirmed the agency's decision. *See* Appendix at 1c to 7c. After the circuit court affirmed the agency's decision and since there was no stay requested, Humana, in reliance upon the certificate of need it had been issued on August 5, 1982, began construction of the hospital in April, 1983.

Still dissatisfied, the opponents took yet another appeal, at this point to the Arkansas Supreme Court. On October 24, 1983, the Arkansas Supreme Court rejected the decisions of the Arkansas SHPDA, of the Arkansas Department of Social Services, and of the Pulaski County Circuit Court, and reversed the circuit court's decision. The court concluded that the SHPDA did not have authority under federal law to approve

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[2] In the proceedings before the Pulaski County Circuit Court the opponents named the Arkansas SHCC as a party respondent along with Humana, the independent agency, and the SHPDA. The SHCC was allowed to realign as a party petitioner in the final order of the circuit court confirming the agency's determination to grant Humana's certificate of need application. The SHCC joined the other opponents in the appeal to the Arkansas Supreme Court.

the application. *See* Appendix at 5a. At the time of the Supreme Court's decision Humana had expended $7 million dollars toward construction of the hospital.[3]

Specifically, the court determined that a certain federal regulatory guideline as to recommended bed-population ratios—set forth by regulation, and not by statute—precluded the SHPDA from exercising any discretion in determining the need for Humana's proposed hospital.[4] This general federal numerical guideline, contained in regulations issued by the federal Department of Health and Human Services to implement the National Health Planning Act, suggests that for certificate of need purposes, "There should be less than four non-Federal, short-stay hospital beds for each 1,000 persons in a health service area except under extraordinary circumstances." 42 C.F.R. §121.201(a). The court reasoned that because there already were more than four acute care hospital beds per 1,000 persons in the Central Arkansas Health Systems Area—which included the city of Sherwood—the federal standard prohibited the issuance of a certificate of need to Humana. In reaching this conclusion, the court expressly rejected Humana's contention that the four-beds-per-1,000 persons standard was a guideline to be considered together with, and given the same weight as, the other criteria identified in the implementing legislation. *See* Appendix at 3a, 5a.

Not only did the court conclude that the federal regulatory guideline was mandatory as a matter of federal law, but the court also held that the guideline was an absolute ceiling because the citizen's advisory groups—the Health Systems Agency and subsequently the State Health Coordinating Council—had each adopted the suggested federal numerical guideline as part of the Health Systems Plan and the State Health Plan. In adopting this alternative holding, the court rejected the argument that construing the two health plans as containing

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[3] Rule 16(a) of the SHPDA rules required action by Humana within one year after the Humana application had been granted, or the certificate of need issued by the SHPDA would have automatically expired.

[4] The Arkansas Supreme Court held that the federal numerical guidelines are conclusively binding except in very limited "exceptional" circumstances, leaving no room for discretionary judgments.

an immutable and mechanical numerical standard effectively shifts control of decision-making in health planning from the state agency—the SHPDA, in which Congress has placed this responsibility—to the HSA and the SHCC, the citizen-industry advisory councils which include potential competitors of new entrants and which is exempt from the review and accountability imposed on the SHPDA.

REASONS FOR GRANTING THE WRIT

I. THE DECISION BELOW IMPROPERLY IMPOSES A MANDATORY FEDERAL STANDARD ON STATE HEALTH PLANNING ACTIVITIES, CONTRARY TO CONGRESSIONAL INTENT AS EMBODIED IN THE NATIONAL HEALTH PLANNING ACT.

A Writ of Certiorari should issue to resolve the classic conflict created by the decision below between federal regulation and the role of the states in implementing the joint federal state program. In this case, the Arkansas Supreme Court has ruled that the role of the states in the health planning process is essentially limited to the mechanical application of what that court concluded is an absolute, federally-mandated numerical ceiling on the construction of new hospital beds. That holding deprives the states of their inherent discretion to regulate the development of local health resources, a discretion Congress clearly confirmed in the National Health Planning Act. The decision below thus unduly restricts the power of the states over health planning and ignores Congress' intent to commit to the states basic decision-making authority for health planning.

A. The Decision Below Deprives The States Of Discretion In Health Planning, In Violation Of The National Health Planning Act.

By holding that federal guidelines promulgated by the federal Department of Health and Human Services impose a binding ceiling on state health planning, the decision below

leaves state governments, in Arkansas as well as in every other certificate of need state, with little or no role in health planning other than to gather the data and to perform the arithmetic calculations necessary to implement the federally-imposed "ceiling." Such a result clearly conflicts with the National Health Planning Act, which enumerates more than a dozen different criteria which the HSA and the SHCC must consider in developing the health system and state-wide health plans, and which the SHPDA must consider in acting upon certificate of need applications. 42 U.S.C. §300n-1(c). Indeed, the Act itself conspicuously avoids any mandatory language in describing the federal guidelines, instead referring to them only as *"recommended* national guidelines" which the states are merely to "take into account" in their health planning activities. 42 U.S.C. §300*l*-2(b)(2) (emphasis added).

Certainly, the numerical guidelines are a goal to be reached over a period of time and must be considered by the SHPDA in evaluating certificate of need applications, as the SHPDA did in this case. Appendix at 2e, 3e. However, it was not the intent of Congress to eliminate the other criteria to be considered by the SHPDA. Had this been the intent, Congress could have merely passed an act limiting the number of beds to four per thousand, or some number established by the Secretary, and saved the money the Federal government now spends for SHPDAs, SHCCs and HSAs throughout the country. Obviously, Congress was attempting to prohibit the building of unneeded hospital beds by establishing *criteria to be considered* by the state agency in the determination of what is or is not needed.

By requiring the states to attribute conclusively dispositive importance to the federal numerical guidelines, the decision below necessarily eliminates the discretion of the state health planning bodies to consider the other factors Congress directed them to evaluate. By necessary implication, the decision below demands that state health planning activities comply with the Secretary's regulatory bed-population guidelines even if the other criteria—embodied in statute, rather than merely in subsequently-adopted regulations—dictate a different con-

clusion. Thus, the decision below not only precludes the SHPDA, the SHCC and the HSAs from exercising the full discretion Congress intended, but also affirmatively prevents these bodies from applying the statutory criteria of the Act when they conflict with the federal regulatory recommendations.

B. The Decision Below Conflicts With Judicial Interpretation Of The Act In Every Other State Which Has Considered The Issue.

The need for Supreme Court review of the impact of the Arkansas Supreme Court decision on national health planning is highlighted by the fact that the decision below conflicts with the decisions of every other state court which has addressed the authority of the states to depart from the federal numerical guidelines. In other states, the courts have determined that the federal "four-beds-per-1,000-persons" guidelines—or similar recommendations for health care facilities other than hospitals—is not a *sine qua non*, but is only one factor among many others to be considered in determining whether a certificate of need application is consistent with the state's health planning goals. *See Northwest Health Care, Inc. v. Idaho Health Facilities Review Board*, Case No. 76772 (4th Jud. D. Id. Jan. 31, 1983); *Mid-Ohio Health Planning Federation v. Certificate of Need Review Board*, No. 81AP-958 (Ct. App., Franklin County, Ohio, April 1, 1982); *West Virginia Health Systems Agency, Inc. v. State Health Planning and Development Agency*, Civ. Act. No. Ap-Ca-80-1 (Cir. Ct., Kanawha County, W. Va., July 2, 1980); *Fairfield Nursing Home v. Whalen*, 407 N.Y.S.2d 923, 64 A.D.2d 802 (Sup. Ct., App. Div. 1978); *Irvington Gen. Hosp. v. Department of Health*, 374 A.2d 49, 51, 149 N.J. Super 461 (App. Div. 1977); *Sturman v. Ingraham*, 383 N.Y.S.2d 60, 64, 52 A.D.2d 882 (Sup. Ct. Div. 1976).

The impropriety of the Arkansas Supreme Court's interpretation of the guidelines is underscored by this Court's discussion of the National Health Planning Act in *National Gerimedical Hospital and Gerontology Center v. Blue Cross* 452 U.S. 378 (1981). As was recognized in *National Gerimedical*,

Congress envisioned that state planning agencies would consider a variety of factors, including effect on competition, in judging a certificate of need application.[5] To the contrary, however, the decision below makes the federal guidelines not merely one factor to be considered, but instead an absolute ceiling that may be exceeded only upon a showing of exceptional circumstances, thus reading out of the Act all the other factors Congress intended be considered. This result contradicts not only the plain language of the National Health Planning Act and the relevant holdings of every other state court, but also this Court's interpretation of the statute in *National Gerimedical.*[6]

Finally, the Arkansas Supreme Court decision has particularly far-reaching implications throughout the United States because, as of January 1, 1984, 49 states had certificate of need review programs under the National Health Planning Act. At least a dozen of those states have incorporated the same federal numerical guidelines in their respective state health plans. If the federal numerical standard in fact is not a recommendation but an absolute ceiling, the SHPDA in each of these states has no authority to grant a certificate of need that exceeds the numerical guidelines, contrary to the present practice in those states. The administration of health planning programs throughout the nation will be subject to fundamental revisions if the Arkansas Supreme Court's interpretation of the National Health Planning Act is allowed to stand.

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[5] Writing for a unanimous Court, Justice Powell noted that Congress, concerned with decreasing competition in the health care provider field, found that "planning agencies should 'give priority . . . to actions which would strengthen the effect of competition on the supply of such services.' " 452 U.S. at 388 n.13 (citations omitted).

[6] Other provisions of the National Health Planning Act evidence a clear Congressional intent that the SHPDA may deviate from the plans developed by the advisory groups. For example, the Act requires the SHPDA to submit a statement of reasons to the HSA whenever it approves a certificate of need application that is "not consistent with" the health systems plan of the HSA. 42 U.S.C. §300m-2(c). Implicit in this requirement is the congressional expectation that the SHPDA may approve applications that are not consistent with the State Health Plan, inasmuch as the State Health Plan is based on the recommendations of the individual HSAs in the state.

II. THE DECISION BELOW VIOLATES THE NATIONAL HEALTH PLANNING ACT AND DENIES HUMANA DUE PROCESS OF LAW BECAUSE IT DEPRIVES THE RESPONSIBLE STATE AGENCY, THE SHPDA, OF DISCRETION IN ADJUDICATING CERTIFICATE OF NEED APPLICATIONS.

The conclusion below that the federal bed-population ratios are mandatory not only deprives the SHCC and the HSAs of much of their discretion to tailor health plans to the areas under their jurisdiction (*see* section I, *supra*), but to an even greater degree unlawfuly hamstrings the SHPDA in exercising its responsibilites to adjudicate certificate of need applications. Whether the reasoning below is read as giving conclusive effect to the guidelines because they are contained in federal regulations or because they are included in the health plans adopted by the HSAs and the SHCC, the result is that the SHPDA is limited to deciding certificate of need cases merely by making arithmetic calculations of bed-population ratios, rather than adjudicating the merits of the application against the numerous criteria mandated by the National Health Planning Act.

Under the Arkansas Supreme Court decision, the bed-population guideline (together with HSA and SHCC decisions as to adoption and implementation of the guideline—to the extent the decision below permits any such decision-making) becomes the sole determinative for evaluating a certificate of need application. Accordingly, the real decision-making occurs, if at all, before the HSAs and the SHCC in their adoption of a plan and implementation of the guideline rather than before the SHPDA—the state agency to which both federal and state law expressly entrust such decisions. Not only does such a result conflict with the federal and state health planning statutes, but it also offends constitutional due process requirements.

A. The Adjudicative Function Under The National Health Planning Act.

Although the National Health Planning Act anticipates significant cooperation among the SHCC, the HSAs and the

SHPDA, there is a clear-cut division of responsibility among these bodies. Each is to make its own decisions, within its area of responsibility on the basis of its own evaluation of all relevant criteria. 42 U.S.C. §300n-1(c). In this division of responsibility, the National Health Planning Act clearly gives the SHPDA—as the only truly governmental agency of the three bodies—exclusive authority to adjudicate whether a certificate of need should issue. 42 U.S.C. §300m-6(a)(5).

The Arkansas Supreme Court decision elevates the HSA's and SHCC's implementation of the bed-population guideline to an absolute, and binds the SHPDA to that single determination to the exclusion of the other factors the SHPDA is statutorily required to consider. The decision thus robs the SHPDA of the discretionary authority it is intended to exercise.[7] This result contradicts the plain language of the Act which requires that the SHPDA be the "sole agency" to administer the certificate of need program and to adjudicate certificate of need applications. 42 U.S.C. §300m(b)(1), §300m-l(b)(1), §300m-2(a)(4)(B). As recognized by this Court in *National Gerimedical,* the HSAs—the citizen-industry advisory groups to health planning—"do not possess regulatory authority over health-care providers." 452 U.S. at 385. Similarly, this Court has recognized the limited rule of HSAs and the SHCC by noting that a SHPDA "is *advised* by a [SHCC], composed in part of representatives of local HSAs." *Id.* at 386 (emphasis added). Thus, on its face, the National Health Planning Act precludes the Arkansas court's *de facto* delegation of SHPDA decision-making authority to the SHCC and HSAs.

Certainly, the federal numerical guidelines (as well as the HSAs and SHCC's recommendations) must be considered by the SHPDA in evaluating applications, as the SHPDA did in this case. However, Congress' express intent to vest the SHPDA with discretionary decision-making authority and the creation by the Act of a detailed administrative adjudicative process is flatly inconsistent with the decision below establishing a single, absolute, nationwide, numerical standard

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[7] As this Court has recognized, removing an administrator's discretion violates the due process rights of the party before the administrator. *See infra* at 15, n.11.

promulgated by federal agency regulations and elevating the advisory recommendations of the HSAs and the SHCC to the level of immutable final decisions. If either the federal guideline or the HSA's and SHCC's planning recommendations are deemed to be absolute and dispositive, as the court below held, the SHPDA is rendered impotent and superfluous, and the joint federal state health planning processes carefully constructed by Congress are thrown into disarray.

B. The Fourteenth Amendment.

Were the Arkansas decision permitted to stand, the health planning procedures that must be followed not only are inconsistent with the National Health Planning Act, but also violate due process rights to an impartial governmental agency evaluation of certificate of need applications, as guaranteed by the fourteenth amendment.

As noted above, and by this Court in *National Gerimedical*, the HSAs and the SHCC are to play an *advisory* role, and are made up of citizen and industry volunteers rather than accountable governmental officials. Indeed, the membership of the HSAs and the SHCC created under the National Health Planning Act must include a significant number of representatives of existing health care providers in the area—precisely the entities most likely to oppose new applications for competitive or other business reasons. *See* 42 U.S.C. § 300*l*-1(b)(3)(C), (HSA membership requirements); 42 U.S.C. §300m-3(b)(1) (SHCC membership requirements). At best, this participation of unavoidably biased persons on the HSAs and SHCC might be permissible were those two bodies limited to the merely advisory role contemplated by the Act.

Under the Arkansas Supreme Court decision, however, the role of these bodies—and these interested individuals—is dramatically expanded from that established by the Act, because those groups exercise the effective authority to determine conclusively the disposition of applications for certificates of need by potential competitors. Further, this potentially-tainted process is conducted before a non-governmental entity outside normal governmental accountability procedures. Finally, the dispositive action—the adoption of the State Health Plan

—usually occurs even before the potential applicant has submitted an application or has had an opportunity to be heard. The decision below which creates such a biased procedure therefore conflicts head on with the due process guarantees of the fourteenth amendment. *Gibson v. Berryhill,* 411 U.S. 574, 578 (1973).

The obvious due process implications of the health planning procedures which would flow were the decision below permitted to stand are graphically illustrated by the circumstances of this case. As was argued to the Arkansas Supreme Court, it was recommended to the local HSA that an amendment to the State Health Plan to reflect the need identified by Humana in its certificate of need application be forwarded to the SHCC.[8] That proposed amendment was never even considered by the SHCC, because prerequisite preliminary approval by the HSA was denied.[9] Significantly, the decisive HSA votes against the request for a plan amendment were cast by employees, lawyers, and doctors associated with the hospitals which opposed Humana's application and which presently oppose petitioner as parties to the case before this Court.[10] The obvious and fundamental unfairness of this procedure assumes constitutional dimensions under the decision of the Arkansas Supreme Court, which makes recourse to the HSA and SHCC for a plan amendment virtually the sole means by which approval might be obtained.

This impermissible result can be avoided only if the National Health Planning Act is construed, according to its

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[8] The plan amendment would have more realistically defined the area to be served by the proposed hospital, an area in which the available hospital beds were well below the suggested guideline ratio. Although rejected by the opponent-dominated HSA, and hence not forwarded to the SHCC, the amendment was recommended by the Facilities Review Committee of the HSA.

[9] *See* Testimony of Thomas W. Boston of the Arkansas SHPDA (R.A. at 430-35). ("R.A." denotes the record abstract submitted by appellants Baptist Medical System, St. Vincent Infirmary and Arkansas Blue Cross and Blue Shield, Inc. to the Arkansas Supreme Court in this case.)

[10] The vote was 21 opposed, with 15 in favor of the proposed amendment. Had the 10 members affiliated with the interested hospitals been disqualified because of their apparent conflict, the plan amendment (which was recommended by the Facilities Review Committee of the HSA) would have carried by 15 to 11. *See* Central Arkansas HSA Board of Directors' meeting, R.A. at 48-49.

plain language, to entrust the discretionary, adjudicative authority to rule on certificate of need applications to the SHPDA—a governmental agency which does not represent any provider. Indeed, Congress' explicit delegation of certificate of need authority exclusively to the SHPDA as the "sole agency" to administer the certificate of need program, 42 U.S.C. §300m-1(b)(1), rather than to a panel consisting of private, competing interests in the health care community, demonstrates legislative awareness of the problems inherent in allowing biased control of the certificate of need decision-making process. Thus, the decision below, by depriving an applicant of the right to a decision by the SHPDA as an impartial agency of the state government having independent discretionary adjudicative power violates the fourteenth amendment's due process guarantees.[11]

III. FAILURE TO REMAND TO THE SHPDA FOR APPLICATION OF THE NEWLY-FORMULATED AND UNFORESEEABLE STANDARD DENIED PETITIONER AN OPPORTUNITY TO PRESENT EVIDENCE UNDER THE NEW STANDARD IN VIOLATION OF THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT.

A Writ of Certiorari should issue because Humana was given no opportunity to present evidence to show that its application should be approved even under the unique and

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[11] By so limiting SHPDA discretion, the decision below not only shifts decision-making authority to a biased decision-maker, but also prevents the agency entrusted with that authority from exercising it, in violation of due process of law. As this Court held thirty years ago, "... if the word discretion means anything in a statutory or administrative grant of power, it means that the recipient must exercise his authority according to his own understanding and conscience." *United States ex rel. Accardi v. Shaughnessy*, 347 U.S. 260, 266-67 (1954). *See also Vitarelli v. Seaton*, 359 U.S. 535 (1959); *Service v. Dulles*, 354 U.S. 363 (1957). Underlying *Accardi*, and the long line of Supreme Court cases based on it, "is a judgment, central to our concept of due process, that government officials no less than private citizens are bound by rules of law." *United States v. Caceres*, 440 U.S. 741, 758 (1979) (Marshall J., dissenting) (footnote omitted). This underlying concept is even more applicable to a case, such as the instant one, where the agencies' discretion is prescribed by federal law. By eliminating the discretion of the SHPDA, the decision below violates this basic tenet of constitutional law.

unforeseen standard ultimately endorsed by the Arkansas Supreme Court. As discussed above in section I, the Arkansas decision reflects a clear break with the law as announced by every other court which has considered the issue, as well as with previous Arkansas practice. Despite this clear break with the past in enunciating dramatically new certificate of need rules, the Arkansas Supreme Court refused to remand this matter to the SHPDA for an evidentiary hearing consistent with the newly-enunciated standard, and instead simply reversed the decision of the circuit court affirming the SHPDA's action.

The due process need for a remand is best demonstrated here by the fact that the SHPDA, in its decision, clearly and correctly enunciated the legal standards it had developed over the years to evaluate certificate of need applications and which it applied to Humana's application. The SHPDA defended that standard through all three separate levels of appeal, including before the Arkansas Supreme Court. Thus, the legal standard the Arkansas Supreme Court ultimately enunciated in the decision below was not "foreshadowed by earlier cases" and certainly "was a 'clear break with the past.'" *Cf. Solem v. Stumes,* 52 U.S.L.W. 4307, 4309 (Feb. 29, 1984). Under these circumstances, the Arkansas Supreme Court decision should only apply prospectively, as Humana argued below. At the very least, however, Humana should have the opportunity to have its application considered under the newly enunciated standard, after an opportunity to present evidence relevant to that standard.

Significantly, after articulating its new rule that the "recommended national guideline," 42 U.S.C. § 300*l*-2(b)(2), constituted a "national mandatory ceiling," the Supreme Court evaluated Humana's application under the new test and reversed the circuit court's decision only because, in the Court's words, "Humana did not submit figures;" "there has been no finding;" "there is no proof;" and "there is no substantial evidence" to satisfy the new legal standard first articulated on appeal. Appendix at 4a, 5a. Even the Arkansas Supreme Court recognized that Humana's argument was limited to a defense of the legal standard applied by the administrative agencies and

court below, and that Humana "could not seriously argue" that the record contained the evidence which would have been introduced had the fact-finding hearings been conducted under the new standard. Appendix at 5a. The Arkansas Supreme Court nevertheless refused to remand.

There can be little doubt that such refusal denied Humana due process under the fourteenth amendment. As Justice Holmes, writing for a unanimous court, stated in a case nearly identical procedurally: "When the act complained of is the action of the [state] supreme court, done unexpectedly at the end of the proceeding, when [the petitioner] no longer had any right to add to the record, it would leave a serious gap in the remedy for infraction of constitutional rights if the party aggrieved in such a way could not come here." *Saunders v. Shaw*, 244 U.S. 317, 320 (1917).

CONCLUSION

For these reasons, petitioner respectfully requests that a Writ of Certiorari be issued to review the judgment and opinion of the Supreme Court of Arkansas.

Respectfully submitted,

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APPENDIX A

SUPREME COURT OF ARKANSAS

No. 83-83

STATEWIDE HEALTH COORDINATING COUNCIL *et al.*,
Appellants,

v.

GENERAL HOSPITALS OF HUMANA, INC., *et al.*,
Appellees.

Opinion Delivered:
October 24, 1983.

Appeal from Pulaski Circuit Court,
Sixth Division; John Langston, Judge.

Reversed.

GEORGE ROSE SMITH, J. The principal appellee, General Hospitals of Humana, which we will refer to as Humana, is a subsidiary corporation of a parent company that owns about 90 hospitals, nearly all of them in the United States. In 1982 Humana applied to the Arkansas Health Planning & Development Agency, which we will refer to as the State Agency, for a certificate of need that would authorize Humana to construct and operate a 150-bed community hospital at Sherwood, in Pulaski County. The application was opposed by the Baptist Medical System, St. Vincent Infirmary, and Arkansas Blue Cross & Blue Shield. After a hearing the director of the State Agency, acting for the Agency, granted the application.

The three protestants asked for a review by an independent agency, as permitted by the State Agency's rules. The Governor appointed the Arkansas Social Services as the independent reviewing agency. A Social Services attorney conducted a hearing and upheld the award of the certificate of need. That decision was affirmed by the circuit court. The

protestants present several arguments for reversal, but we need consider only one: The State Agency was not authorized to grant a certificate of need that was inconsistent with the State Health Plan. On the record that argument must be sustained, which disposes of the case.

First, a preliminary procedural matter. Humana has filed a motion to dismiss the appeal as moot, asserting that it was compelled by the State Agency's Rule 16 to enter into a construction contract (and it actually began construction) within one year after the certificate of need was awarded on August 5, 1982, else the certificate would have expired. Without implying that Humana's motion to dismiss is otherwise well taken, we note two flaws in its argument. First, Rule 16 provides that for good cause the State Agency may extend the time up to an additional six months. Humana apparently had good cause to seek an extension, but it did not do so. Second, Rule 16 also states that evidence of an obligation to make the capital expenditure must be received by the State Agency within one year after its approval of the project or the approval will expire. An obligation, under Rule 16, is deemed to have been incurred within the year if the applicant enters into an enforceable contract for the construction, acquisition, lease, or financing of a capital asset. Hence the execution of a construction contract was not the only choice. Apparently the Humana company fulfilled the financing alternative, as Humana produced testimony on November 9, 1982, that bonds for the project had been issued. We conclude that Humana was not threatened with an immediate expiration of its certificate of need.

Turning to the merits, we must emphasize at the outset that there is in progress a national effort to limit the construction of new hospitals—an effort initiated by Congress, carried forward by regulations issued by the Secretary of Health and Human Services, and supported by legislation enacted by the states, which are expected to participate in the program and receive federal funds for health care. Among the statutes and regulations pertinent to this case are 42 U.S.C.A. §§300k to 300n-6 (1982); 42 C.F.R. §§121.1 to 124.607 (1982); and Ark. Stat. Ann. §§82-2301 to -2314 (Repl. 1976 and Supp. 1983).

The policy of restricting hospital construction stems from Congress's belief that competition among hospitals, unlike competition in the market place, does not reduce the cost of in-patient hospital services to the consuming public. 42 U.S.C.A. §300k-2(b)(1). To the contrary, the testimony in the case at bar shows that such competition actually increases hospital charges. Fixed hospital costs are so great that an empty bed costs about half as much to maintain as an occupied bed. Hospitals compete not for patients but for doctors, who usually select the patient's hospital. Hospitals vie with one another in acquiring expensive equipment, with unnecessary and costly duplication of facilities. Hospital charges are apt to be paid without question by public and private health insurers. The hard fact is, as one witness stated bluntly: "The cost of hospital care is just outrageous to the consumer."

Congress has attacked the problem by attempting to limit the number of licensed hospital beds. The federal regulation, 42 C.F.R. §121.201(a), provides: "*Standard.* There should be less than four non-Federal, short-stay hospital beds for each 1,000 persons in a health service area *except under extraordinary circumstances.*" (Our italics). The ensuing discussion in subsection (b) then states: "Health Maintenance Organizations and similar groups have shown that high quality care can be provided with less than 3 beds per 1,000 population. Thus, 4 beds per 1,000 population is a ceiling, not an ideal situation." The Arkansas State Health Plan contains the same less-than-4-beds-per-1,000 limitation that was written into the federal regulations. Ark. State Health Plan, pp. 184-185.

The federal law, in its endeavor to control the proliferation of hosptial beds throughout the nation, contemplates that each state will be divided by its governor, subject to revision by the Secretary, into health service areas so that the distribution of health care units can be conformed to local conditions. Arkansas has been divided into four such areas. This case arose within the Central Arkansas area, composed of Faulkner, Lonoke, Monroe, Prairie, Pulaski, and Saline Counties. This area, like other health service areas, has its own Health Systems Agency and Health Systems Plan. There is also a detailed State Health Plan, which must be and was adopted by the Statewide Health Coordinating Council, must be revised by that Council

at least every three years, and is to be administered by the State Agency. 42 U.S.C.A. §300m-2(a)(2); 42 U.S.C.A. §300m-3(c)(2)(A).

Various different figures were given in the testimony about the number of hospital beds in the Central Arkansas area, because the witnesses did not count the beds in the same way. There is no question, however, but that the area, like most of the nation, is overbedded in that its licensed hospital beds already exceed the federal and state maximum of 4 beds per 1,000 persons. Humana did submit figures purporting to show that in 1986 there would be no overage even with its 150 added beds, but when this isolated testimony is weighed along with the other proof it cannot be considered substantial evidence. *See Ark. Savings & Loan Assn. Bd. v. Central Ark. S. & L. Assn.*, 260 Ark. 58, 538 S.W.2d 505 (1976). Moreover, both the State Agency and the reviewing independent agency found that Humana's application is inconsistent with the need determinations of the Central Arkansas Health Systems Plan.

The State Health Plan is not inflexible. Both the federal and state law permit the maximum bed limit to be exceeded locally to meet exceptional conditions, which are specified as being (1) an unusually high proportion of persons over 65 years old, (2) seasonal population fluctuations, (3) rural areas in which, for example, a majority of the residents would otherwise be more than 30 minutes travel time from a hospital, (4) urban areas having a large number of beds compensated by fewer beds in the same metropolitan area, and (5) areas having referral hospitals attracting nonresident patients. 42 C.F.R. §121.201(a); State Health Plan, pp. 184-185. There has been no finding that any such exceptional condition exists. The independent reviewing agency referred broadly to adjustments for age and rural area, but there is no proof with respect to aged residents in the area, and the area Health Systems Plan states that over 90% of the population in the area lives within 30 minutes of an existing hospital. Specifically, both the Memorial Hospital in North Little Rock and the Rebsamen Hospital in Jacksonville are within the area that Humana expects to serve.

Thus it is established without substantial dispute that Humana's application for a 150-bed hospital in an area already

overbedded is contrary to the Central Arkansas Health Systems Plan and to the State Health Plan. On this critical point the State Agency's own Rule 4(d) requires that the State health Plan be adhered to:

> Each decision of the State Agency (or the appropriate administrative or judicial review body) to issue a certificate of need must be consistent with the State Health Plan, except in emergency circumstances that pose an imminent threat to public health.

Despite this rule adopted by the State Agency itself, both that agency and the independent agency made what is denominated as a "Finding of Fact," though it contains only what is really a conclusion of law:

> The application, while inconsistent with the need determinations of the Health Systems Plan, is consistent with the goals, objectives, and need determinations of the State Health Plan.

There is no substantial evidence to support that finding. The principal goals and objectives of the entire federal and state program are to reduce the cost of hospital care by prohibiting the construction of new hospitals that would exceed the limit of 4 beds per 1,000 population. The application proposes that the limit be exceeded. It is a contradiction to declare the application consistent with the State Health Plan when in fact it is flatly and unmistakably contrary to that plan.

Counsel for Humana do not and could not seriously argue that the proof supports the State Agency's determination. Instead, it is contended that the federal and state laws are mere guidelines which the director of the State Agency is free to disregard if he chooses to do so. If that were true, the entire federal and state effort to confine the number of hospital beds to the target limitation would be futile, for every agency director would be free to ignore the limitation whenever he saw fit to do so. The short answer is that the laws and regulations specify the exceptional circumstances under which the fixed bed limit may be exceeded. No such exception has been demonstrated in this instance.

Reversed.

Hays, J., not participating.

APPENDIX B

OFFICE OF THE CLERK
SUPREME COURT OF THE STATE OF ARKANSAS
ARKANSAS COURT OF APPEALS
LITTLE ROCK

December 12, 1983

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Re: 83-83 Statewide Health Coordinating Council et al v. General Hospitals of Humana, Inc. et al

Gentlemen:

The Court made the following order in the above styled case today:

"Petitions for Rehearing are denied. Purtle, J., would grant. Hays, Jr., not participating."

Sincerely yours,

Dona L. Williams, Clerk

DLW:rh
Enclosure
cc: J. C. Deacon
Harold H. Simpson II
Charles R. Nestrud
Jacque Alexander
W. H. "Buddy" Sutton

SUPREME COURT OF ARKANSAS

No. 83-83

STATEWIDE HEALTH COORDINATING COUNCIL, *et al.*
Respondents.

v.

GENERAL HOSPITALS OF HUMANA, INC., *et al.*
Petitioners.

Opinion Delivered 12/12/83

APPEAL FROM PULASKI COUNTY CIRCUIT COURT; HON. JOHN LANGSTON, JUDGE.

(PETITION FOR REHEARING)

DISSENT

John I. Purtle, Associate Justice. I feel we made a mistake in this case when we overruled the Pulaski County Circuit Court in affirming the decision of the state agency granting a certificate of need to General Hospitals of Humana, Inc. to build a hospital in Sherwood, Arkansas. I do not question that our decision was a correct one under a strict construction theory. However, I am of the opinion that we could have adopted a less narrow construction and affirmed the decision of the lower court.

The state agency is an arm of the state and has authority to bind the state when acting within the authorization granted to it. The state agency determined that there was need for a hospital in Sherwood and pursuant to its granted authority issued a certificate of need for construction. The other area hospitals intervened and unsuccessfully tried to prevent the

certificated from being issued. After it was granted the matter was appealed to the circuit court where the action of the agency was affirmed. Without question Humana should have waited on the appellate process before commencing construction but that is hindsight, which is always 20/20. Nevertheless, by proceeding, they were acting in full compliance with the law as evidenced by their certificate of need which had been declared valid. There is no question about petitioner acting in good faith in reliance upon the action of the state. We have held the state may be estopped to deny that which has previously been approved. *Foote's Dixie Dandy, Inc. v. McHenry Adm'r,* 270 Ark. 816, 607 S.W.2d 323 (1980).

I agree with petitioner's argument that federal law contemplates the states will on occasion issue a certificate of need which is not in strict compliance with the standards. The best evidence of this view is the law itself which is set out in 42 U.S.C.A. § 300 M-2(c) stating:

> If a State Agency makes a decision in carrying out a function described in paragraph (4) [Certificate of need decisions], (5), or (6) of subsection (a) of this section which is not consistent with the goals of the applicable HSP or the priorities of the applicable AIP, the State Agency shall submit to the appropriate health systems agency a detailed statement of the reasons for the inconsistency.

When provisions for its departure are included within the law, rule or regulation, it is not necessary for courts to create exceptions. If there was a departure from the formula in this case it appears it may have well been of the type envisioned when the law was enacted.

It is obvious that we are dealing with a case of over-regulation here. Governments are not authorized to act except within the confines of the power granted to them by the people. I do not believe the people intended to grant the government the power to regulate every facet of their affairs. A less narrow construction of these statutes and regulations would allow the

state agency to depart from strict compliance, as it did in this case. I believe public policy requires that we interpret these statutes in a manner consistent with the decisions of the state agency, the independent agency, the Attorney General's office and the circuit court. In the interest of public policy I would apply a very broad interpretation of these restrictive regulations. After all, the health, safety and welfare of the residents of north Pulaski County will be affected by this decision.

The cost of medical care has skyrocketed within the past few years. Many poor and needy people can no longer afford even basic medical needs. It seems to me that competition will drive the cost of hospitalization down, not up as argued by respondents. Furthermore, the cost of hospitalization is not the only consideration involved here. Human lives may well be at stake in this instance; acutely ill persons who reside in northern Pulaski County may not survive the longer trip to other area hospitals. No value can be placed upon a human life but it seems to me the life of a north Pulaski County resident should be valued the same as one south of the river. As we interpret the laws where the health, safety and welfare of people are at issue, we should insure that these rights are jealously guarded, and that our helpless citizens are protected. The least we should do in this matter is to return it to the state agency in control for a more complete development of the facts. It may well be that this certificate of need was issued for valid reasons. I would grant rehearing.

APPENDIX C

IN THE CIRCUIT COURT OF
PULASKI COUNTY, ARKANSAS, SIXTH DIVISION

No. 82-7500

BAPTIST MEDICAL SYSTEMS, INC. *et al.*,
Petitioners,

v.

ARKANSAS HEALTH PLANNING AND
DEVELOPMENT AGENCY, *et al.*,
Respondents.

MEMORANDUM AND ORDER

This cause comes on to be heard on the Petitioners' Notice of Appeal and Petition for Judicial Review of the Decision and Order of the Respondent, Ivan H. Smith, acting for the Independent Agency, the Division of Social Services of the Arkansas Department of Human Services, which affirmed after an administrative review the Decision and Order of The Arkansas Health Planning and Development Agency ("State Agency") which had granted a Certificate of Need ("CON") to General Hospitals of Humana Inc. ("Humana") for the construction of a 150-bed full service general hospital to be located in Sherwood, Arkansas. The court, having reviewed the pleadings, the testimony regarding irregularities not appearing in the record, the complete transcript and record in this matter, briefs submitted by counsel, and having heard arguments of counsel, find:

On January 15, 1982, General Hospitals of Humana Inc., filed an application with the State Agency for a Certificate of Need to construct a new 150-bed hospital in Sherwood, Arkansas.

On July 7, 1982, the State Agency approved the application for the CON for Humana and issued a "Conditional" Certificate of Need to Humana on August 5, 1982.

Governor White appointed Mr. Ivan Smith to serve as the "Independent Agency" to conduct an administrative appeal on August 6, 1982. An administrative appeal was held, and on October 20, 1982, the decision of the State Agency was affirmed by the Independent Agency.

This matter comes before this Court for judicial review following the decision of the Independent Agency.

The Petitioners have done an excellent job of arguing that the Humana application is not consistent with the State Health Plan, and more specifically, that the Arkansas Health Planning Law and State Agency regulations require the approval of the Statewide Health Coordinating Council ("SHCC") before a CON can be issued.

In regard to the latter argument of the petitioners, petitioners rely on Ark. Stat. Ann. §82-2311(a), which provides:

> "The State Health Planning and Development Agency, with the advice, consent and approval of the Statewide Health Coordinating Council is hereby authorized and directed to implement the below described Certificate of Need in this state."

They further rely on Rule 1 of the State Agency Rules:

> "In the performance of its functions, the State Agency acts with the advice, consent and approval of the Statewide Health Coordinating Council appointed by the Governor."

It is the principal argument of the Petitioners that SHCC approval is mandatory for the State Agency to be able to issue the Certificate of Need. The Court does not find this to be true.

It should be first noted that Ark. Stat. Ann. §82-2311(a) does not speak of SHCC approval as a prerequisite to the issuance of a Certificate of Need. It states that the advice, consent and approval of the Statewide Health Coordinating

Council is hereby authorized and directed to implement the "Certificate of Need *Program* in this State." (emphasis added).

Reading the Statute in its entirety, it should be noted that other paragraphs are specific in stating that bed need and existing facilites are to be considered in making their decision, but that no one consideration is absolutely determinative. Specifically, Paragraph (b) states that a certificate of need shall be obtained from the State Health Planning and Development Agency prior to any construction. Paragraph 9(d) specifically states that the Agency shall issue a CON "If *it* finds that the proposed project requiring approval is reasonably necessary . . ." (emphasis added), and then goes on to list 13 areas of consideration, including:

> "(4) The availability and adequacy of health care services in facilities which are currently serving the defined population and which conform to State standards."

The Statute seems to generally state the same thing again in Paragraph (f) when it states:

> "In the administration of this Act, consideration shall be given to the efficiency of the utilization of an existing health facility which is or will be serving the defined population to be served by a proposed new health facility . . ."

These two paragraphs, (4) and (f), make it obvious that the State Agency only takes bed need into consideration and that the determination of SHCC in this regard is only advisory, rather than mandatory, and under the provisions of Paragraph (d) that it is the State Agency that considers these criteria and makes the determination as to the issuance of a Certificate of Need.

Petitioners also rely upon the National Health Planning and Resource Development Act, Section 1517(a)(5), 42 U.S.C. Section 300m-6(a)(5), which provides:

> "(5) The "certificate of need" program shall provide that . . . (b) each decision to issue a certificate of

> need (i) may only be issued by the State Agency and (ii) shall . . . be consistent with the State Health Plan in effect for such state."

Petitioners further state that State Agency Rule 4(d) also states the same rule:

> "(d) Each decision of the State Agency . . . to issue a certificate of need must be consistent with the State Health Plan . . ."

However, the State Health Plan states its purpose on page iii of the Plan to be:

> "(5) To guide the actions of the Statewide Health Coordinating Council and the State Health Planning and Development Agency in their performance of required functions under P.L. 93-641 and Act 558 of 1975."

Again Ark. Stat. Ann. §82-2311, Section 5(d) states that the Agency:

> "Shall issue a certificate of need if it finds that the proposed project requiring approval is reasonably necessary . . ."

The Statute then goes on to state what the Agency shall take into consideration. It allows the State Agency to make its own decision as to what is the relationship of the proposal to the Health Systems Plans and the State Health Plans. It does not direct the State Agency to absolutely accept the determination of SHCC in this regard.

The clear policy is that the Certificate of Need decision belongs only to the State Agency after considering the criteria set out in the Statute.

Petitioners further contend that a preponderance of the evidence reflects that the State Agency acted arbitrarily and capriciously in granting the Certificate of Need upon the evidence presented. This Court does not try an administrative appeal *de novo* but instead determines whether the State

Agency's actions were arbitrary and capricious. *Independence Savings & Loan Association v. Citizens Federal Savings and Loan Association,* 265 Ark. 203, 577 S.W.2d 390 (1977). The contention that the State Agency's actions was arbitrary and capricious must be addressed with a more narrow standard of review. Administrative action may be regarded as arbitrary and capricious only where it is not supportable on any rational basis. *First National Bank of Fayetteville v. Smith,* 508 F.2d 1371 (8th Cir. 1974); *White County Guaranty Savings and Loan v. Farmers and Merchants Bank,* 262 Ark. 893, 562 S.W.2d 582 (1978).

In reviewing the record, it is notable that the Independent Agency, in its decision, did consider each of the 13 requirements set out by Ark. Stat. Ann. §82-2311(d) and made specific findings of fact and conclusions of law upon each of the 13 enumerated considerations.

The testimony of Dr. Kelly Mosely, an expert witness, is particularly notable in considering the adequacy of the evidence presented to the State Agency. He states, at Page 169 of the transcript:

> "In the particular case of North Pulaski, Lonoke, Faulkner, Prairie Counties, the State Plan has identified medical(ly) underserved areas through the Department of Health and Human Services that forty-five point eight percent (45.8%) of the population perhaps could be classified as medical(ly) underserved. This has to do with the development and identification of lack of resources in combination with aged and poverty population."

and, at Page 170 of the transcript:

> "The finding was that perhaps over fifty percent (50%) were seeking medical care outside their community."

The State Agency was not limited by the recommendations of the SHCC since consideration was given to the recommendations of the SHCC, and even though the SHCC must give its consent and approval to the planning document and to the rules and regulations, the State Agency has the discretion to issue a certificate of need based on its findings and its interpretation of the rules and the planning documents.

After considering the decision and order of the State Agency in its entirety and reviewing the testimony and exhibits appearing in the record, I find sufficient evidence in the record to reasonably support the actions of the State Agency in issuing a Certificate of Need to Humana, and to support the affirmance of that action by the Independent Agency that reviewed its decision.

In conclusion, the Court finds there was substantial evidence of record to support the decision and order of the Independent Agency, which is the final decision of the State Agency under the State Agency Rule 11(13), which was made after due consideration of all relevant criteria under the Arkansas Health Planning Act and State Agency Rules and that the correct procedure was followed. The Court further finds that the administrative findings, inferences, conclusions and decision are not:

1) in violation of constitutional or statutory provisions;
2) in excess of the statutory authority of the Independent Agency or the State Agency;
3) made upon unlawful procedure;
4) affected by other error or law;
5) arbitrary, capricious or characterized by abuse of discretion.

The Court recognizes that the SHCC has an important interest in the outcome of this proceeding, in particular its interest in its jurisdiction, in the State Health Plan, and in the procedures followed in this and future CON reviews. The SHCC's arguments are of the type that should be reviewed at

the appellate level. Therefore, the SHCC should remain a party to this proceeding and the SHCC's motion to be realigned as a petitioner in accordance with its interest should be granted.

IT IS, THEREFORE, CONSIDERED, ORDERED and ADJUDGED, that the SHCC be and hereby is a party to this proceeding, and is realigned as a petitioner in accordance with its interest, that the decision and order of the Independent Agency affirming the decision and order of the State Agency to issue a CON to Humana is affirmed; the temporary stay of the order of the Independent Agency granted by this Court on November 12, 1982, is hereby set aside, effective December 28, 1982.

Entered nunc pro tunc to December 28, 1982, this 28th day of January, 1983.

JOHN LANGSTON
Circuit Judge

APPENDIX D

BEFORE THE DIVISION OF SOCIAL SERVICES
DEPARTMENT OF HUMAN SERVICES
OF THE STATE OF ARKANSAS

BAPTIST MEDICAL SYSTEMS, ST. VINCENT INFIRMARY,
ARKANSAS BLUE CROSS AND BLUE SHIELD, INC.
Plaintiffs

VS.

ARKANSAS STATE HEALTH PLANNING AND
DEVELOPMENT AGENCY, *et al.*
Defendants

DECISION AND ORDER

INTRODUCTION

Now on this 25th day of August, 1982 comes on to be heard for Administrative Review, the decision of the Arkansas State Health Planning and Development Agency to issue a certificate of need to Humana, Inc. to construct a new one hundred fifty (150) bed hospital in Sherwood, Arkansas.

By agreement of all parties, the hearing was continued until October 13, 1982. Briefs were submitted by all parties on September 30, 1982. Reply briefs were submitted on October 8, 1982, and oral arguments were presented on October 13, 1982.

This review is conducted by authority of Rule 11(13) of the Procedures for State Agency review promulgated by the Arkansas Health Planning and Development Agency. The hearing officer is sitting as a State Agency designated by the Governor pursuant to the Arkansas Health Planning and Development rules.

FINDINGS OF FACT

1. The Health Development rules require only an administrative review of the decision of the Health Planning Agency. The interpretation of this rule by the State Agency does not provide for a de novo hearing, but only for a review of the decision of the State Agency.

2. The Administrative Procedures Act, at Ark. Stat. Ann. §5-708, does not require a de novo hearing on an Administrative Review of the agency's determination, but does require conformity to certain procedures, all of which have been followed in this hearing as outlined below:

A. All parties were afforded an opportunity for a hearing after reasonable notice. The notice included the time, place and nature of the hearing.

B. A statement of the legal authority and jurisdiction under which the hearing was to be held was given.

C. A short, plain statement of matters of fact and laws asserted was given, and each party was given an opportunity to question all matters of fact contained in the record and all law asserted.

D. An opportunity was afforded parties to respond and present evidence and arguments on all issues involved with the restriction that an offer of evidence must relate to the procedures or further proffered with evidence as to why the evidence was either prohibited or not given in a hearing before the Agency. The record included:

1) All pleadings, motions, and intermediate rulings,

2) Evidence received or considered, including, on request of any party, a transcript of oral proceedings or any part thereof,

3) A statement of matters officially noticed,

4) Offers of proof, objections and rulings thereon,

5) Proposed findings and exceptions thereto,

6) All staff memoranda or data submitted to the hearing officer or members of an agency in connection with their consideration of the case.

E. Findings of fact in this hearing are based exclusively on the evidence and all matters officially noticed.

3. The Arkansas State Health Planning and Development Agency was established under Act 558 of 1975 which was amended by Act 808 of 1981.

4. The State Health Planning and Development Agency, with the advice, consent and approval of the Statewide Health Coordinating Council was authorized and directed to implement a certificate of need program for the State of Arkansas. The program was promulgated in June of 1980 pursuant to this enabling act.

5. The State Health Plan provides on page iii:

"... the State Health Plan was designed to assist in the decision making process relative to conductance of the State Certificate of Need Program."

6. Page 3 of the State Plan provides that there are five (5) major purposes of a State Plan. These are:

1) To be the basis for development of a coordinated and comprehensive approach, over time, to the identification and resolution of health problems in the State.

2) To offer guidance to State government in the development and articulation of State health and health related policies (by the Governor, legislature and other State officials).

3) To offer guidance in resource allocation decisions in support of State health policy so that, as far as possible, equal access to quality health care at a reasonable cost in the State can be achieved, and denied to no groups or individuals.

4) To serve as an instrument for cost containment by preventing wasteful duplication of facilities and services, encouraging utilization of appropriate levels of care, and

by fostering health education, prevention, and early intervention as necessary and economical alternatives to crisis medicine.

5) To guide the actions of the Statewide Health Coordinating Council and the State Health Planning and Development Agency in the performance of their required functions under P.L. 93-641 and Act 558 of 1975.

7. Section 121.201 of the National Guidelines for Health Planning provides that there should be less than four non-Federal, short-stay hospital beds for each 1,000 persons in a health service area except under extraordinary circumstances and proceeds to set our (sic) five exceptions to this rule. Exceptions involve conditions that may be adjusted within the discretion of the State Health Planning Agency (sic).

8. Section 5(d) of Act 558 of 1975 provides:

"The Agency shall issue a certificate of need if it finds that the proposed project requiring approval is reasonably necessary to provide health care to the defined population in a manner which is economically practicable, which maintains high quality standards, and which is appropriate to the timely and economic development of adequate and effective health services in the area. In making such determination, the Agency shall take into consideration:

(1) Recommendations of the appropriate Health Systems Agency(s).

(2) The relationship of the proposal to the Health Systems Plans and the State Health Plans.

(3) The need for health care services in the area or the requirements of the defined population.

(4) The availability and adequacy of health care services in facilities which are currently serving the defined population and which conform to State standards.

(5) The need for special equipment and services in the areas which are not reasonably

and economically accessible to the defined population.

(6) The need for research and educational facilities.

(7) The probable economics and improvement in service that may be derived from the operation of joint central services or from joint, cooperative, or shared health resources which are accessible to the defined population.

(8) The availability of sufficient manpower in the professional disciplines required to maintain the facility.

(9) The plans for and development of comprehensive health services and facilities for the defined population to be served. Such services may be either direct or indirect through formal affiliation with other health programs in the area and shall include preventive, diagnostic, treatment, and rehabilitation services.

(10) Whether or not the applicant has obtained all relevant approvals, licenses or consents required by law for its incorporation or establishment.

(11) The needs of members, subscribers and enrollees of institutions and health care plans which operate or support particular hospitals for the purpose of rendering health care to such members, subscribers and enrollees.

(12) In the case of an application by a hospital established or operated by a religious body or denomination, the needs of the members of such religious body or denomination for care and treatment in accordance with their religious or ethical convictions may be considered to be public need.

(13) The proposed facility will be adequately funded."

9. The law places the authority to issue a certificate of need upon the State Agency, and this decision may be made without the consent and approval of the Statewide Health Coordinating Council.

10. On August 5, 1982 the Arkansas Health Planning and Development Agency issued a conditional Certificate of Need to General Hospitals of Humana, Inc.

11. The Arkansas State Health Plan and Development Agency did consider the thirteen requirements set out in Ark. Stat. Ann. §82-2311(d) as outlined below:

1) Recommendations of the Area Health Planning Authority.

FINDINGS OF FACT

The recommendations of the Areawide Health Planning Authorities were considered. The board's recommendation was disregarded after the Health Planning Agency considered:

a) The conflicting opinions within the Board,

b) That there was an obvious conflict of interest by some of the Board members who did not disqualify themselves from voting even though they admitted the conflict of interest,

c) The Board did have the opportunity to hear all relevant information that had been presented to the HSA committee during its review, and

d) The Health Planning and Development Agency had additional testimony presented to it under cross-examination during a state hearing which allowed it to have more complete information on which to make a decision.

CONCLUSION OF LAW

The reviewing authority finds that the recommendations of the Areawide Health Planning Authorities were considered and properly disregarded from the findings of facts which the reviewing authority adopts.

2) The relationship of the proposal of (sic) the Areawide Health Plan.

FINDINGS OF FACT

The relationship of the Humana application to the Areawide Health Plan was discussed in a two day hearing at which time counsel for the various parties presented evidence on all avenues of possible consistencies and possible inconsistencies between the proposal and the plan. From this hearing the State Agency made the following findings:

a) All applicable state certificates of need and procedures were adhered to,

b) The application as submitted, adequately addressed all but one of the twenty-one review criteria,

c) The application, while inconsistent with the need determinations of the Health System Plan, is consistent with the goals, objections, and need determinations of the State Health Plan.

CONCLUSION OF LAW

After review of all materials, the reviewing authority finds that there was sufficient evidence to uphold all findings of the State Agency; and, upon a review of the record, further adopts and makes these findings its own.

3) The need for health care services in the area of the requirements of the defined population.

FINDINGS OF FACT

The State Agency made the following findings regarding the need for services:

a) A rapid population growth has occurred in the defined area and a relatively large concentration of people exists in said area,

b) The demonstration of need in itself addresses the issue of duplication and renders the issue a positive consideration,

c) The SHPDA considered the use and proximity of the hospitals within the defined area and found that the projected need would offset any adverse affect (sic) on the area's hospitals,

d) The integrity of the State acute care bed need plan is maintained and the decision does not affect existing need determinations as published and promulgated.

CONCLUSION OF LAW

a) The reviewing authority finds that there was sufficient evidence to support the above four findings and adopts the findings made by the State Agency.

b) Four general areas were discussed in the review hearing. These areas of discussion were thoroughly briefed by all parties. They include:

1) The designation of the service area. The reviewing authority finds the service area as such is not restricted by the State Plan as long as it is consistent with the various requirements of the federal and state laws and regulations. The reviewing authority finds that when the conditions which requires (sic) adjustments are considered, including the age of the population, and the fact that the area includes rural areas, that a proper designation of a service area was made.

2) The project (sic, "projection") of further needs, including bed space within the service area. The reviewing authority finds that proper consideration was made of the needs by the State Agency when consideration was given to operational beds rather than licensed bed space. By considering only licensed beds consideration is given to beds that were licensed, but not yet constructed, to phantom beds and to beds that were built but unstaffed. Since many of the licensed beds were not available in the hospitals the number of licensed beds does not give a true picture to the public of the bed space that is available. The above factors result in a bed occupancy rate that is a lower rate than the federal standards even though actual bed space is not available to the public that needs admission to the hospital.

3) Whether the agency was limited in its determination to issue a certificate of need either by the recommendations of the Statewide Health Coordination (sic) Council or by the State Health Plan.

The reviewing authority finds that the Agency was not limited by the recommendations of either the Council or the Plan since consideration was given to the recommendations of the council and this reviewing agency determines that even though the council must give its consent and approval to the planning document and to the rules and regulations, that the State Agency has the discretion to issue a certificate of need based on its findings and its interpretation of the rules and the planning documents.

4) Whether the Federal Act and/or State Plan limits in any way the discretion of the State Health Planning Agency (sic) in issuing its certificate of need.

The reviewing authority finds that the limitation to (sic) the State Agency must be found in a violation of the requirements of the Federal Act and/or State Plan and the reviewing authority finds no violation. The Federal Act and State Plan offer only guidelines that were followed by the State Agency.

4) The availability and adequacy of health services in facilities which are currently servicing the defined population which conforms to state standards.

FINDINGS OF FACT

The State Agency found that there are currently 388 licensed and approved beds in the service area, leaving an unmet need between 104 and 186 beds, or an average of 145.

CONCLUSION OF LAW

a) The reviewing authority finds that the Health Planning Agency did consider at greath [sic] length the availability and adequacy of health care services in the facility, both in the proposed area and the central Arkansas HSA Area; that the availability of the facility in the area involved considerable speculation regarding growth of the area and whether or not the outmigration of certain areas of the proposal would occur. Since this is speculative, the reviewing authority finds that there were sufficient facts presented from which the State Agency and the reviewing authority could conclude that a certificate of need should be issued.

b) The reviewing authority further finds that the Health Services are not being adequately provided in the rural part of the proposed service area; that there is a rapid growth occurring in the defined area and that the existing facilities are not now taking care of the health services in this area. Whether or not the proposed hospital can prevent an out-migration of patients in certain areas continues to be speculative, but since the need does exist the reviewing authority concludes that a certificate of need should be issued to the proposed hospital to try to adequately meet these needs.

5) The need for special equipment and services in the area which are not reasonably and economically accessible to the defined population.

FINDINGS OF FACT

The State Agency found that the determination of need as evaluated in the SHPDA is consistent with the Statewide Health Coordinating Council guidance for determining need and is based on the population and analysis of use patterns.

CONCLUSION OF LAW

The reviewing agency finds that the Health Planning Agency took into consideration the needs for special equipment and that the needs for special equipment were normally taken care of by the Tertiary level service hospitals in Little Rock which were related primarily to the question of outmigration, and that the special needs were considered by the State Agency in making their decision.

6) The needs for research and education facilities.

FINDINGS OF FACT

The State Agency addressed in its written opinion only those points that required explanation with the statement that those points not addressed were either not applicable or adequately addressed in the application.

CONCLUSION OF LAW

The needs for educational facilities were considered by State Agency (sic) to the extent of the application proposals. There was no allegation of need for research facilities and the educational facilities were directed primarily to the local needs of staffing the NCCH facility.

7) The probably [sic] economics and improvements in services that may be derived from the operation of joint central service or from joint, cooperative, or shared health resources which are accessible to the defined population.

FINDINGS OF FACT

The State Agency found that the projected need for the new facility would offset any adverse effect on the area hospitals. In reaching this decision the State Agency properly found that:

1) Currently and in the future inpatient services will not be locally accessible to many residents of the service area unless additional inpatient resources are provided. NCCH will provide hospital resources which are accessible to residents of North Pulaski, Prairie, Faulkner and Lonoke Counties.

2) Presently many residents in the proposed area of service are forced to seek routine medical care outside of their local community because adequate quantities of inpatient services are not available.

3) NCCH will contribute to the accomplishment of the established Central Arkansas Health Systems Plan goals of development, a comprehensive emergency service system in the service area.

CONCLUSION OF LAW

The reviewing authority reaches the same conclusion and adopts the agency findings.

8) The availability of sufficient manpower in the professional disciplines required to maintain the facility.

FINDINGS OF FACT

a) While not making a specific findings (sic), the State Agency concluded that this criteria was adequately addressed,

b) Humana offered testimony that they would initiate a major recruitment program approximately one year prior to the opening of the hospital,

c) Humana will transfer from within their organization of over ninety (90) hospitals those personnel who wish to move to Little Rock from other areas of the country,

d) There are 447 registered nurses per one hundred thousand (100,000) population in the State of Arkansas,

e) There are 790 registered nurses per one hundred thousand (100,000) population in the area to be serviced by the proposed hospital,

f) The national average of RN's per one hundred thousand population is 523,

g) The Baptist Medical Center's application for additional beds was withdrawn after they alleged that there was sufficient manpower in the professional discipline to maintain an additional 120 beds,

h) The number of graduates in the Little Rock SMCA School of Nursing since 1948 shows almost a 36% increase from 1978 to 1981,

i) Humana, Inc. has an established practice and procedure for nurse recruitment, plus a mobil transfer corps of approximately one hundred nurses which could be used to assure an adequate supply of registered nurses.

j) After a full hearing, the State Agency considered the availability of manpower question and considered the availability to be sufficient.

CONCLUSION OF LAW

This Agency finds that there was sufficient evidence presented to not only convince the State Agency but also the reviewing authority that sufficient manpower remains available in the area to adequately staff the proposed hospital. The reviewing authority, therefore, adopts the above findings of fact of the State Agency.

9) The plans for and development of comprehensive health services and facilities for the defined population to be

served. Such services may be either direct or indirect through formal affiliation with other health programs in the area and shall include preventive, diagnostic, treatment and rehabilitation services.

FINDINGS OF FACT

The State Agency found that the determination of need as evaluated by the SHPDA is consistent with the Statewide Health Coordination (sic) Council guidance for determining need and is based on the population and analysis of use patterns.

CONCLUSION OF LAW

a) The reviewing authority finds that the State Agency determination of need was evaluated for the defined population to be served and adopts the State Agency's findings.

b) The State Agency's evaluation was consistent with the Statewide Health Coordination (sic) Council guidance for determining need.

10) Whether or not the applicant has obtained all relevant approvals, licenses or consents required by law for its incorporation or establishment.

FINDINGS OF FACT

The State Agency found in their review process that all applicable state and federal criteria, state and local health plans, and other information presented was in keeping with state law, federal law, state rules and regulations.

CONCLUSION OF LAW

The reviewing authority finds that applicant has obtained all relevant approvals, licenses or consents required by law for its incorporation.

11) The needs of members, subscribers and enrollees of institutions and health care plans which operate or support particular hospitals for the purpose of rendering health care to such members, subscribers and enrollees.

There was no need for the State Agency to consider this point since the application was for a general hospital to serve the entire service area and was not limited to rendering health care to any particular religious or partisan group.

12) In the case of an application by a hospital established or operated by a religious body or denomination, the needs of the members of a religious body or denomination for care and treatment in accordance with their religious or ethical convictions may be considered to be public need.

There was no need for the State Agency to consider this point since the application was for a general hospital to serve the entire service area and was not limited to rendering health care to any particular religious or partisan group.

13) The proposed facility will be adequately funded.

FINDINGS OF FACT

The State Agency found that the facility would be properly funded from corporation funds.

CONCLUSION OF LAW

The reviewing authority finds that the corporation will be adequately funded.

DECISION

The final conclusions of the reviewing authority are as follows:

The decision of the Arkansas State Health Planning and Development Agency should be affirmed, since it is based upon

substantial evidence of record and was made pursuant to the laws, rules, regulations, standards, and criteria governing the Arkansas State Health Planning and Development Agency.

Based upon a review of the entire record the reviewing authority finds that the twenty-one review criteria specified under Rule 13 criteria (sic) for the State Agency's review have been considered. Not all points are relevant to this hearing, but all points have been considered and the record reflects substantial evidence to support the ultimate finding of SHPDA that the certificate of need should be issued.

From a review of all of the record, briefs, reply briefs and argument, the reviewing authority does hereby affirm the decision of the Arkansas State Health Planning and Development Agency.

IVAN H. SMITH
Director of Legal Services
Arkansas Social Services
Reviewing Agency

APPENDIX E

THE ARKANSAS STATE HEALTH PLANNING AND DEVELOPMENT AGENCY

In Re: Application of General Hospitals of Humana, Inc., Sherwood, Arkansas

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A. *Review:* The Arkansas State Planning and Development Agency (SHPDA) reviewed oral and written presentations by means of application, public hearings and other communications concerning the referenced proposed hospital. In the review process the SHPDA considered all applicable State and Federal criteria, State and local health plans and other information presented in the course of review.

1. Of the applicable review criteria, each were adequately addressed by the applicant with the exception of need which will be discussed at length under Section B, Assessment in this paper. The remainder of the criteria that require explanation are included in that same section (assessment).

2. State and local health plans are addressed in the assessment section under the criteria review with explanation.

3. Other information not previously considered and submitted in the course of review are noted in the assessment section.

B. *Assessment:* SHPDA consideration, evaluation, and analysis of the presented arguments and statistical information are contained herein. The assessment is based on documented material filed and maintained by the SHPDA.

1. Review Criteria: The content of this portion of the written opinion contains only those that require explanation. It is understood that those not addressed herein were either not applicable or adequately addressed in the application.

a) Relationship to the State Health Plan (SHP) and Health Systems Plan—the SHP does not delineate new service areas but rather defines need based on existing services (sic) areas. A written policy of the SHP includes the changes allowable when new and/or updated information is available. The introduction of a new service area not previously considered falls under this policy.

The Health Systems Plan is not applicable in this instance, in that during the development process of the SHP, the Health Systems Agency was undergoing phaseout activities based on federal directives that local health planning organizations would be dissolved. The Health Systems Agency as a result did not update or revise their most current HSP (1980), nor did the HSA provide input to the current SHP.

b) Need of the Population—The application specified that Faulkner, Lonoke, Prairie and North Pulaski Counties (Hill Township) comprise the service area for the three existing hospitals and the one proposed hospital. Analysis of use patterns of the population in the geographic area does not support the inclusion of Faulkner and Prairie Counties. Less than two percent (2%) of the discharges of these area hospitals were to each of Prairie and Faulkner Counties. Considering the factors influencing patient use (referrals, transportation arteries, services provided, and others), a significant portion of Lonoke and North Pulaski County will be served by facilities in this area. With the (sic) consideration, it appears reasonable to estimate that the service area population will be approximately 203,680 in 1986. This projection is based on the high rate of growth through the area (25.4% over the last ten years including the community of Sherwood where the facility is to be constructed which had a growth rate of 284.4%). Assuming a total service area of 205,000 which includes the 2% population of Faulkner and Prairie Counties previously mentioned at 4 beds per 1,000

population as established by the Statewide Health Coordinating Council, a total of 820 beds would be required to adequately serve the population. Recognizing that 20-30% of the population require tertiary level services and that an undeterminable percentage of the people would continue to out-migrate for primary and secondary level services, it is reasonable to estimate that about 30-40% of the people would seek care outside the defined area. Therefore, approximately 123,000 to 143,500 people by 1986 would require between 492 to 574 beds at 4 beds per 1,000 population. There are currently 388 licensed and approved beds in the area, leaving an unmet need between 104 and 186 beds; or an average of 145.

2. Health Systems Agency Recommendation—The SHPDA attended and reviewed the information and discussion of the HSA and its committee addressing the Humana application. While the Board voted to recommend disapproval of the proposed hospital, the Facilities Review Committee recommended approval of the same proposal. Considering the conflicting opinions within the Board and the information presented to the HSA Committee and the Board, it is the opinion of this agency that the Board did not have an opportunity to hear all relevant information as had the committee during its review meeting. Further, the SHPDA conducted a State hearing allowing affected and interested parties to testify and present evidence across cross-examination. The duration of the hearing exceeded sixteen (16) hours and substantial and exhaustive testimony was heard and later examined by the SHPDA.

C. *Findings:* The conclusions and final decisions of the SHPDA were based on considerations presented herein as well as other information and/or on file. The decision to approve the Humana application is based on the following:

1. All applicable State Certificate of Need rules and procedures were adhered to;

2. The application as submitted adequately addressed all but one of the twenty-one review criteria;

3. The application while inconsistent with the need determinations of the Health Systems Plan is consistent with the goals, objectives and needs determination of the State Health Plan;

4. The determination of need as evaluated by the SHPDA is consistent with the Statewide Health Coordinating Council guidance for determining need and is based on the population and analysis of use patterns. (The SHPDA does not find with the HSA staff or applicants analysis of need for beds) (sic);

5. The HSA Board did not have an opportunity to hear presentations from representatives of the proposed facility as did the HSA Committee and the SHPDA;

6. A rapid population growth has occurred in the defined area, and a relatively large concentration of people exists in said area;

7. The demonstration of need in itself addresses the issue of duplication and renders the issue a positive consideration;

8. The SHPDA considered the use and proximity of the hospitals within the defined service area and found that the projected need would offset any adverse affect (sic) on the area's hospitals;

9. The integrity of the State acute care bed need plan is maintained and the decision does not affect existing need determinations as published and promulgated.

Signed/Joel E. North, Director, July 7, 1982

APPENDIX F

OFFICE OF THE CLERK
SUPREME COURT OF THE STATE OF ARKANSAS
ARKANSAS COURT OF APPEALS
LITTLE ROCK

December 12, 1983

DONA L. WILLIAMS
CLERK
ROBIN HENDERSON
CHIEF DEPUTY
LESLIE W. STEEN
DEPUTY
JANIE OWEN
DEPUTY
VERNON L. DUTTON
DEPUTY
MELISSA FULLER
DEPUTY
DENISE SELBY
DEPUTY

Robert D. Smith, III
Attorney at Law
P. O. Box 3238
Little Rock, AR 72203

Robert L. Brown
Attorney at Law
810 Tower Building
Little Rock, AR 72201

Re: 83-83 Statewide Health Coordinating Council et al v. General Hospitals of Humana, Inc. et al

Gentlemen:

The Court made the following order in the above styled case today:

"Appellees' motion for stay of mandate is granted. Purtle, J., would deny."

Sincerely yours,

Dona L. Williams, Clerk

DLW:rh
cc: George Harper
W. H. "Buddy" Sutton
J. C. Deacon
Charles R. Nestrud
Harold H. Simpson, II
Jacque Alexander

APPENDIX G

STATUTES AND REGULATIONS IN PERTINENT PART

42 U.S.C. § 300*l*. Health service areas
Requirements; factors considered in establishing boundaries

(a) Except as provided in section 300n-5 of this title, there shall be established, in accordance with this section, health service areas throughout the United States with respect to which health systems agencies shall be designated under section 3001-4 of this title. Each health service area shall meet the following requirements:

(1) The area shall be a geographic region appropriate for the effective planning and development of health services determined on the basis of factors including population and the availability of resources to provide all necessary health services for residents of the area.

* * *

Notice to State governors; publication in Federal Register; boundary designations: revision, review by Secretary; consultations; hearing

(b)(1) Within thirty days following January 4, 1975, the Secretary shall simultaneously give to the Governor of each State written notice of the initiation of proceedings to establish health service areas throughout the United States. Each notice shall contain the following:

(A) A statement of the requirement (in subsection (a) of this section) of the establishment of health service areas throughout the United States.

(B) A statement of the criteria prescribed by subsection (a) of this section for health service areas and the procedures prescribed by this subsection for the designation of health service area boundaries.

(C) A request that the Governor receiving the notice (i) designate the boundaries of health service areas within his State, and, where appropriate and in cooperation with the Governors of adjoining States, designate the boundaries within his State of health service areas located both in

his State and in adjoining States, and (ii) submit (in such form and manner as the Secretary shall specify) to the Secretary, within one hundred and twenty days of January 4, 1975, such boundary designations together with comments, submitted by the entities referred to in paragraph (2), with respect to such designations.

At the time such notice is given under this paragraph to each Governor, the Secretary shall publish as a notice in the Federal Register a statement of the giving of his notice to the Governor and the criteria and procedures contained in such notice.

* * *

§300*l*-1. Health systems agency

Definition

(a) For purposes of this subchapter, the term "health systems agency" means an entity which is organized and operated in the manner described in subsection (b) of this section and which is capable, as determined by the Secretary, of performing each of the functions described in section 300*l*-2 of this title. The Secretary shall by regulation establish standards and criteria for the requirements of subsection (b) of this section and section 300*l*-2 of this title.

Legal structure; staff; governing body; responsibilities; composition; selection; support; conflict of interest; limitation of liability; exception; acceptance of contributions; public meeting; invasion of privacy; reports; accounting procedures; access to information

(b)(1) A health systems agency for a health service area shall be—

(A) a nonprofit private corporation (or similar legal mechanism such as a public benefit corporation) which is incorporated in the State in which the largest part of the population of the health service area resides, which is not a subsidiary of, or otherwise controlled by, any other private or public corporation or other legal entity, and which only engages in health planning and development functions;

(B) a public regional planning body if (i) it has a governing board composed of a majority of elected officials of units of general local government or it is authorized by State law (in effect before January 4, 1975) to carry out health planning and review functions such as those described in section 300*l*-2 of this title, and (ii) its planning area is identical to the health service area; or

(C) a single unit of general local government if the area of the jurisdiction of that unit is identical to the health service area.

A health systems agency may not be an educational institution or operate such an institution.

* * *

(3)(A) A health systems agency which is a public regional planning body or unit of general local government shall, in addition to any other governing body, appoint a governing body for health planning in accordance with subparagraph (C) which shall have the responsibilities prescribed by subparagraph (B), and which shall have exclusive authority to perform the functions described in section 300*l*-2 of this title. Any other health systems agency shall have a governing body composed, in accordance with subparagraph (C), of not less than ten members and of not more than thirty members, except that the number of members may exceed thirty if the governing body has established another unit (referred to in this paragraph as an "executive committee") composed, in accordance with subparagraph (C), of not less than ten members and not more than thirty members of the governing body and has delegated to that unit the authority to take such action (other than the establishment and revision of the plans referred to in subparagraph (B)(ii)) as the governing body is authorized to take.

* * *

(C) The membership of the governing body and the executive committee (if any) of an agency shall meet the following requirements:

(i) A majority (but not more than 60 per centum of the members) shall be (I) residents of the health service

area served by the entity who are consumers of health care and who are not providers of health care, and (II) broadly representative of the health service area and shall include individuals representing the principal social, economic, linguistic, handicapped, and racial populations and geographic areas of the health service area and major purchasers of health care (including labor organizations and business corporations) in the area. (ii) The remainder of the members shall be residents of, or have their principal place of business in, the health service area served by the agency who are providers of health care and who represent (I) physicians (particularly practicing physicians) dentists, nurses, optometrists, (II) podiatrists, physician assistants, and other health professionals health care institutions (particularly hospitals, long-term care facilities, rehabilitation facilities, alcohol and drug abuse treatment facilities, and health maintenance organizations), (III) health care insurers, (IV) health professional schools, (V) the allied health professions, and (VI) other providers of health care. Not less than one-half of the providers of health care who are members of the governing body or executive committee of a health systems agency shall be direct providers of health care (as described in section 300n(3) of this title) and of such direct providers of health care, at least one shall be a person engaged in the administration of a hospital.

* * *

§300*l*-2. Functions of health systems agencies

* * *

Health Systems and Annual Implementation Plans; establishment; requirements; review

(b) In providing health planning and resources development for its health service area, a health systems agency shall perform the following functions:

(1) The agency shall assemble and analyze data concerning—

(A) the status (and its determinants) of the health of the residents of its health service area,

(B) the status of the health care delivery system in the area and the use of that system by the residents of the area,

(C) the effect the area's health care delivery system has on the health of the residents of the area,

(D) the number, type, and location of the area's health resources, including health services, manpower, and facilities,

(E) the patterns of utilization of the area's health resources, and

(F) the environmental and occupational exposure factors affecting immediate and long-term health conditions.

The agency shall also assemble and report to the Secretary such data (including data on the personnel, facilities, and other resources needed to meet the goals set forth in the agency's health system plan) as the Secretary may require to carry out his responsibilities under section 300k-1(e) of this title. The Secretary may not require the assembling and reporting of data under this paragraph which is regularly collected by an entity of the Department of Health and Human Services under a provision of law other than this subchapter. In carrying out this paragraph, the agency shall to the maximum extent practicable use existing data (including data developed under Federal health programs) and coordinate its activities with the cooperative system provided for under section 242k(e) of this title.

(2) The agency shall, after appropriate consideration of the recommended national guidelines for health planning policy issued by the Secretary under section 300k-1 of this title, the priorities set forth in section 300k-2 of this title, and the data developed pursuant to paragraph (1), established (in accordance with the format established pursuant to section 300m-3(c)(1) of this title), at least triennially review, and amend as necessary a health systems plan (hereinafter in this subchapter referred to as the "HSP") which shall be a detailed statement of goals (A) describing a healthful environment (primarily with regard

to health care equipment and to health services provided by health care institutions, health care facilities, and other providers of health care and to other health resources) and health systems in the area which, when developed, will assure that quality health services will be available and accessible in a manner which assures continuity of care, at reasonable cost, for all residents of the area; (B) which are responsive to the unique needs and resources (including entities described in section 300n-1(c)(7) of this title) of the area; (C) which take into account the national guidelines for health planning policy issued by the Secretary under section 300k-1 of this title respecting supply, distribution, and organization of health resources and services; (D) which are responsible to statewide health needs as determined by the State health planning and development agency; (E) which describe the institutional health services (as defined in section 300n(5) of this title) needed to provide for the well-being of persons receiving care within the health service area, including, at a minimum, acute inpatient (including psychiatric inpatient, obstetrical inpatient, and neonatal inpatient), rehabilitation, and long-term care services; and (F) which describe other health services needed to provide for the well-being of persons receiving care within the health service area, including, at a minimum, preventive, ambulatory, and home health services and treatment for alcohol and drug abuse.

* * *

§300m. Designation of State health planning and development agencies

Authority of Secretary to enter into agreements

(a) For the purpose of the performance within each State of the health planning and development functions prescribed by section 300m-2 of this title, the Secretary shall enter into and renew agreements (described in subsection (b) of this section) for the designation of a State health planning and development agency for each State.

Agreement for designation; conditional designation; extension, termination, and expiration of agreement; renewals; return to conditional designation status

(b)(1) A designation agreement under subsection (a) of this section is an agreement with the Governor of a State for the designation of an agency (selected by the Governor) of the government of that State as the State health planning and development agency (hereinafter in this subchapter referred to as the "State Agency") to administer the State administrative program prescribed by section 300m-1 of this title and to carry out the State's health planning and development functions prescribed by section 300m-2 of this title.

* * *

§300m-1. State administrative program

Requisite features of program

(b) The State Program of a State must-

(1) provide for the performance within the State (after the designation of a State Agency and in accordance with the designation agreement) of the functions prescribed by section 300m-2 of this title and specify the State Agency of the State as the sole agency for the performance of such functions (except as provided in subsection (b) of such section) and for the administration of the State Program;

* * *

§300m-2. State health planning and development functions

Performance by State agency of State designated under section 300m(b)(3) of this title

(a) Each State Agency of a State designated under section 300m(b)(3) of this title shall, except as authorized under subsection (b) of this section, perform within the State the following functions:

* * *

(4)(A) Serve as the designated planning agency of the State for the purposes of section 1320a-1 of this title if

the State has made an agreement pursuant to such section, and (B) administer a State certificate of need program which applies to the obligation of capital expenditures within the State and the offering within the State of new institutional health services and the acquisition of major medical equipment and which is consistent with standards established by the Secretary by regulation. A certificate of need program shall provide for procedures and penalties to enforce the requirements of the program. In performing its functions under this paragraph the State Agency shall consider recommendations made by health systems agencies under section 300*l*-2(f) of this title.

(5) After consideration of recommendations submitted by health systems agencies under section 300*l*-2(f) of this title respecting new institutional health services proposed to be offered within the State, make findings as to the need for such services.

• • •

Statement

(c) If a State agency makes a decision in carrying out a function described in paragraph (4), (5), or (6) of subsection (a) of this section which is not consistent with the goals of the applicable HSP or the priorities of the applicable AIP, the State Agency shall submit to the appropriate health systems agency a detailed statement of the reasons for the inconsistency.

• • •

§300m-3. Statewide Health Coordinating Council

Advisory function

(a) A State health planning and development agency designated under section 300m of this title shall be advised by a Statewide Health Coordinating Council (hereinafter in this section referred to as the "SHCC") which (1) is organized in the manner described by subsection (b) of this section, and (2) performs the functions listed in subsection (c) of this section.

Membership; chairman; conduct of meetings

(b)(1) A SHCC of a State shall be composed in the following manner:

(A)(i) A SHCC shall have no fewer than sixteen representatives (or if the number of representatives on the SHCC to which health systems agencies are entitled under the second sentence of clause (iii) is less than sixteen, no fewer than the number to which they are entitled) appointed by the Governor of the State from lists of nominees submitted to the Governor by each of the health systems agencies designated for health service areas which fall, in whole or in part, within the State. Each agency shall submit a number of nominees to the Governor which is at least twice the number of representatives on the SHCC to which the agency is entitled.

(ii) Each such health systems agency shall be entitled to the same number of representatives on the SHCC, except that the number of representatives on the SHCC to which a health systems agency designated for a health service area which is not entirely within the State shall be a number which is based on the relationship of the population of the portion of such health service area within the State to the population of the largest health service area located entirely within the State, except that each such agency shall be entitled to at least one representative on the SHCC.

(iii) Except as otherwise provided in clause (ii) and this clause, each such health systems agency shall be entitled to at least two representatives on the SHCC. If there are more than ten health systems agencies within a State, each health systems agency within such State shall be entitled to at least one representative on the SHCC. Of the representatives of health systems agencies on the SHCC, not less than one-half shall be individuals who are consumers of health care and who are not providers of health care.

(B) In addition to the appointments made under subparagraph (A), the Governor of the State may appoint

such persons (including State officials, public elected officials, and other representatives of governmental authorities within the State) to serve on the SHCC as he deems appropriate; except that (i) the number of persons appointed to the SHCC under this subparagraph may not exceed 40 per centum of the total membership of the SHCC, and (ii) a majority of the persons appointed by the Governor shall be consumers of health care who are not also providers of health care.

(C) Not less than one-half of the providers of health care who are members of a SHCC shall be direct providers of health care (as described in section 300n(3) of this title).

(D) Where one or more hospitals or other health care facilities of the Veterans' Administration are located in a State, the SHCC shall, in addition to the appointed members, include, as a nonvoting, ex officio member, an individual whom the Chief Medical Director the Veterans' Administration shall have designated as a representative of such facilities.

(E) Members of the SHCC who are consumers of health care and who are not providers of health care shall include individuals who represent rural and urban medically underserved populations if such populations exist in the State.

* * *

Other functions

(c) A SHCC shall perform the following functions:

(1) Establish (in consultation with the health systems agencies in the State and the State Agency) a uniform format for HSP's and review and coordinate at least triennially the HSP and review at least annually the AIP of each health systems agency within the State and report to the Secretary, for purposes of his review under section 300n-4(c) of this title, its comments on such HSP and AIP.

(2)(A) Prepare, review at least triennially, and revise as necessary a State health plan which shall be made

up of the HSP's of the health systems agencies within the State. Such plan may, as found necessary by the SHCC, contain revisions of such HSP's to achieve their appropriate coordination or to deal more effectively with statewide health needs as determined by the State Agency of the State. The plan shall also describe the institutional health services (as defined in section 300n(5) of this title) needed to provide for the well-being of persons receiving care within the State, including, at a minimum, acute inpatient (including psychiatric inpatient, obstetrical inpatient, and neonatal inpatient), rehabilitation, and long-term care services; and also describe other health services needed to provide for the well-being of persons receiving care within the State, including, at a minimum, preventive, ambulatory, and home health services and treatment for alcohol and drug abuse. The plan shall also describe the number and type of resources, including facilities, personnel, major medical equipment, and other resources required to meet the goals of the plan and shall state the extent to which existing health care facilities are in need of modernization, conversion to other uses, or closure and the extent to which new health care facilities need to be constructed or acquired. Each health systems agency which participates in the SHCC shall make available to the SHCC its HSP for integration into the State health plan and shall, as required by the SHCC, revise its HSP to achieve appropriate coordination with HSP's of the other agencies which participate in the SHCC or to deal more effectively with statewide health needs as determined by the State Agency of the State.

* * *

§300m-6. Certificate of need program

Determination of need for equipment and services; criteria for review of application; timetable for delivery of equipment and services; withdrawal of certificate; maximum amount of capital expenditures; review of changes

(a) The certificate of need program required by section 300m-2(a)(4)(B) of this title shall, in accordance with this section, provide for the following:

(1) Review and determination of need under such program for—

(A) major medical equipment and institutional health services, and

(B) capital expenditures,

shall be made before the time such equipment is acquired, such services are offered, substantial expenditures are undertaken in preparation for such offering, or capital expenditures are obligated.

(2) The acquisition and offering of only such equipment and services as may be found by the State Agency to be needed; and the obligation of only those capital expenditures found to be needed by the State Agency. Except as otherwise authorized by this section, review under the program of an application for a certificate of need may not be made subject to any criterion and the issuance of a certificate of need may not be made subject to any condition unless the criterion or condition directly relates to—

(A) criteria prescribed by section 300n-1(c) of this title,

(B) criteria prescribed by regulations of the Secretary promulgated under section 300n-1(a) of this title before October 4, 1979, or

(C) criteria prescribed by regulation by the State Agency in accordance with an authorization prescribed by State law.

The Secretary may not require a State to include in its program any criterion in addition to criteria described in subparagraphs (A) and (B).

(3) An application for a certificate of need for an institutional health service, medical equipment, or a capital

expenditure shall specify the time the applicant will require to make such service or equipment available or to obligate such expenditure and a timetable for making such service or equipment available or obligating such expenditure. After the issuance of a certificate of need, the State Agency shall periodically review the progress of the holder of the certificate in meeting the timetable specified in the approved application for the certificate. If on the basis of such a review the State Agency determines that the holder of a certificate is not meeting such timetable and is not making a good faith effort to meet it, the State Agency may, after considering any recommendation made by the health systems agency which received a report from the State Agency on such review, withdraw the certificate.

(4) In issuing a certificate of need, the State shall specify in the certificate the maximum amount of capital expenditures which may be obligated under such certificate. The program shall, in accordance with regulations promulgated by the Secretary, prescribe the extent to which a project authorized by a certificate of need shall be subject to further review if the amount of capital expenditures obligated or expected to be obligated for the project exceed the maximum specified in the certificate of need.

(5) The program shall provide that (A) the requirements of section 300n-1 of this title shall apply to proceedings under the program, and (B) each decision to issue a certificate of need (i) may only be issued by the State Agency, and (ii) shall, except in emergency circumstances that pose a threat to public health, be consistent with the State health plan in effect for such State under section 300m-3(c) of this title.

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§300n-1. Procedures and criteria for review of proposed health system changes

Development and publication

(a) In conducting reviews pursuant to subsections (e), (f), and (g) of section 300*l*-2 of this title or in conducting any other reviews of proposed or existing health services, each health systems agency shall (except to the extent approved by the Secetary) follow procedures, and apply criteria, developed and published by the agency in accordance with regulations of the Secretary; in performing its review functions under section 300m-2 of this title, a State Agency shall (except to the extent approved by the Secretary) follow procedures, and apply criteria, developed and published by the State Agency in accordance with regulations of the Secretary; and in performing its review functions a Statewide Health Coordinating Council shall (except to the extent approved by the Secretary) follow procedures and apply criteria developed and published by the Council in accordance with regulations of the Secretary. Procedures and criteria for reviews by health systems agencies, State Agencies, and Statewide Health Coordinating Councils may vary according to the purpose for which a particular review is being conducted or the type of health services being reviewed. Health systems agencies, the State Agency, and, if appropriate, the Statewide Health Coordinating Council within each State shall cooperate in the development of procedures and criteria under this subsection to the extent appropriate to the achievement of efficiency in their reviews and consistency in criteria for such reviews. The Secretary shall review at least annually regulations promulgated under this section and provide opportunity for the submission of comments by health systems agencies, State Agencies, and Statewide Health Coordinating Councils on the need for the revision of such regulations. At least forty-five days before the initial publication of a regulation proposing a revision in a regulation of the Secretary under this section, the Secretary shall, with respect to such proposed revision, consult with and solicit the recommendations from health systems agencies, State Agencies, and Statewide Health Coordinating Councils.

Minimum procedures

(b) Each health systems agency, State Agency, and Statewide Health Coordinating Council shall include in the procedures required by subsection (a) of this section at least the following:

* * *

(12) The following procedural requirements with respect to proceedings under a certificate of need program:

* * *

(D) The program shall provide that each decision of the State Agency to issue, not to issue, or to withdraw a certificate of need or to approve or disapprove an application for an exemption under section 300m-6(b) of this title shall, upon request of any person directly affected by such decision, be reviewed under an appeals mechanism consistent with State law governing the practices and procedures of administrative agencies or, if there is no such State law, by an entity (other than the State Agency) designated by the Governor.

(E) Any person adversely affected by a final decision of a State Agency with respect to a certificate of need or an application for an exemption under section 300m-6(b) of this title and a health systems agency if the decision respecting the certificate of need is inconsistent with a recommendation made by the agency to the State Agency with respect to the certificate of need may, within a reasonable period of time after such decision is made (and any administrative review of it completed), obtain judicial review of it in an appropriate State court. The decision of the State Agency shall be affirmed upon such judicial review unless it is found to be arbitrary or capricious or not made in compliance with applicable law.

* * *

Minimum Criteria

(c) Criteria required by subsection (a) of this section for health systems agency, State Agency, and Statewide Health Coordinating Council review shall include consideration of at least the following:

(1) The relationship of the health services being reviewed to the applicable HSP, AIP, and State health plan.

(2) The relationship of services reviewed to the long-range development plan (if any) of the person providing or proposing such services.

(3) The need that the population served or to be served by such services has for such services.

(4) The availability of alternatives, less costly, or more effective methods of providing such services.

(5) The relationship of services reviewed to the existing health care system of the area in which such services are provided or proposed to be provided.

(6) In the case of health services proposed to be provided—

(A) the availability of resources (including health manpower, management personnel, and funds for capital and operating needs) for the provision of such services,

(B) the effect of the means proposed for the delivery of such services on the clinical needs of health professional training programs in the area in which such services are to be provided,

(C) if such services are to be available in a limited number of facilities, the extent to which the health professions schools in the area will have access to the services for training purposes,

(D) the availability of alternative uses of such resources for the provision of other health services, and

(E) the extent to which such proposed services will be accessible to all the residents of the area to be served by such services.

(7) The special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located or in adjacent health service areas. Such entities may include medical and other health professions schools, multidisciplinary clinics, specialty centers, and such other entities as the Secretary may by regulation prescribe.

(8) The special needs and circumstances of health maintenance organizations.

(9) In the case of a construction project—

(A) the costs and methods of the proposed construction, including the costs and methods of energy provision, and

(B) the probable impact of the construction project reviewed on the costs of providing health services by the person proposing such construction project and on the costs and charges to the public of providing health services by other persons.

(10) The special circumstances of health service institutions and the need for conserving energy.

(11) In accordance with section 300k-2(b) of this title, the factors which affect the effect of competition on the supply of the health services being reviewed.

(12) Improvements or innovations in the financing and delivery of health services which foster competition, in accordance with section 300k-2(b) of this title, and serve to promote quality assurance and cost effectiveness.

(13) In the case of health services or facilities proposed to be provided, the efficiency and appropriateness of the use of existing services and facilities similar to those proposed.

(14) In the case of existing services or facilities, the quality of care provided by such services or facilities in the past.

The criteria established by any health systems agency, State Agency, or Statewide Health Coordinating Council under paragraph (8) shall be consistent with the standards and procedures established by the Secretary under section 300e-5(c) of this title.

42 C.F.R. §121.201 (1983) General hospitals—bed supply.

(a) *Standard.* There should be less than four non-Federal, short-stay hospital beds for each 1,000 persons in a health service area except under extraordinary circumstances. For purposes of this section, short-stay hospital beds include all non-federal short-stay hospital beds (including general medical/surgical, children's, obstetric, psychiatric, and other short-stay specialized beds). Conditions which may justify adjustments to this ratio for a health service area include:

(1) *Age.* Individuals 65 years of age and older have a higher hospital utilization rate--up to four times that of the general population—than any other age group. Bed-population ratios for health service areas in which the percentage of elderly people is significantly higher (more than 12 percent of the population) than the national average may be planned at a higher ratio, based on analyses by the HSA.

(2) *Seasonal population fluctuations.* Large seasonal variations in hospital utilization may justify higher ratios. Plans should reflect vacation and recreation patterns as well as the needs of migrant workers and other factors causing usual seasonal variations.

(3) *Rural areas.* Hospital care should be accessible within a reasonable period of time. For example, in rural areas in which a majority of the residents would otherwise be more than 30 minutes travel time from a hospital, the HSA may determine, based on analyses, that a bed-population ratio of greater than 4 per 1,000 persons may be justified.

(4) *Urban areas.* Large numbers of beds in one part of a Standard Metropolitan Statistical Area (SMSA) may be compensated for by fewer beds in other parts of the SMSA. Health service areas which include a part of an SMSA may plan for bed-population ratios higher than 4 per 1,000 persons reflecting existing patterns if there is a joint plan among all HSAs serving the SMSA which provides for less than 4 beds per 1,000 persons in the SMSA as a whole.

(5) *Areas with referral hospitals.* In the case of referral institutions which provide a substantial portion of specialty services to individuals not residing in the area, the HSA may exclude from its computation of bed-population ratio the beds utilized by referred patients who reside outside both the SMSA and the HSA in which the facility is located.